World Vision Relief & Development, Inc.

✓ WVRD/Haiti FY91
FINAL EVALUATION REPORT
LA GONAVE CHILD SURVIVAL PROJECT
December 30, 1994

Grant No.: PDC-0500-G-00-1065-00

Beginning Date: October 1, 1991
Ending Date: September 30, 1994

Submitted to:

PVO Child Survival Grant Program
Office of Private and Voluntary Cooperation
Bureau for Food for Peace and Voluntary Assistance
Room 103C, SA-8
Agency for International Development
515 23rd Avenue, NW
Washington, DC 20523

PVO Headquarters Contact:

Lawrence Casazza, M.D., M.P.H.
World Vision Relief & Development, Inc.
220 I Street, NE
Washington, DC 20002

BEST AVAILABLE COPY

ELECTRONIC DOCUMENT APPEARS AS IT WAS RECEIVED

TABLE OF CONTENTS

LIST OF ACRONYMS

ADS	Health Agents/Agents de Sante
ALRI	Acute Lower Respiratory Infection
AOPS	Association of Private Voluntary Health Organizations
CDD	Control of Diarrhea1 Disease
cs	Child Survival
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
EOP	End-of-project
EPI	Expanded Programme on Immunization
km	Kilometers
KPC	Knowledge, Practice, Coverage
MHA	Maternal Health Assistant
MOH	Ministry of Health
NGO	Non-government Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid (vaccine)
USAID	United States Agency for International Development
WV	World Vision
WVRD	World Vision Relief & Development

EXECUTIVE SUMMARY

In October 1987, World Vision Relief & Development (WVRD) initiated a Child Survival project (CSP) on the island of La Gonave, Haiti. In October 1991, WVRD received a $379,960 three-year grant from the United States Agency for International Development (USAID) to continue implementation of Child Survival activities, with a match of $246,111 from WVRD.

In September 1993, a midterm evaluation of the La Gonave CSP concluded that "the project had made exceptional progress and accomplished much more than expected given extremely difficult circumstances. Many end-of-project objectives [had] already been obtained". (Midterm Evaluation Report, La Gonave Child Survival Project, La Gonave Island, Haiti, October 1993, page 1).

In September 1994, the final evaluation was conducted to measure the impact of the CSP at the end of the three-year period, to evaluate the sustainability of the project, and to draw out ***lessons*** learned. As appropriate, the successes and lessons learned from this project will be used to make recommendations that will improve the quality of services offered to the population of La Gonave, and that may be replicated by other USAID-supported Child Survival projects.

The team was composed of an external evaluator, a data processing expert, three sociologists and an external reporter.

From September 11 to October 9, 1994, the team evaluated the progress of the project using the following tools:

a) a 30-cluster Knowledge, Practice Coverage (KPC) survey
b) semi-structured focus groups with the health committees
c) interviews with project staff, staff of other PVO's on the island, and representatives of the Ministry of Health.

Portions of this report were written by Maryse Gourdet, M.D., M.P.H. (consultant) based on data received from Arsene Ferrus, M.D., M.P.H. (coordinator); Vasco Thernelan, Sociologist, and Fred Leopold, Sociologist (assistant for focus groups realization, tabulation and analysis)

Overall, the evaluation team concluded that the project maintained and increased the impact observed during the midterm evaluation. In spite of severe constraints, end of project objectives have been achieved. Exceptional progress was evidenced in this final evaluation, especially in community organization and participation, and their efforts to achieve sustainability.

Key recommendations address strengthening of community capacity to sustain CSP project activities.

I. INTRODUCTION

A. Background

The Child Survival Project (CSP) of World Vision Haiti is located on the island of La Gonave, 30 kms west of Port-au-Prince, the capital city of Haiti. The project initially started in October 1987 and later received a three year extension to continue the project from October 1991 to September 1994.

Nearly 85,000 people live on La Gonave. Approximately 16% are children under five and 25% are women of childbearing age. The island covers a mountainous area of 855 kms2. La Gonave has been largely forgotten by the country's governments mainly because of its remote geographicallocation. Roads are extremely difficult and sometimes non-existent. The communication system is poor or non-existent. La Gonave experiences scarce rainfall and limited water sources. Much of the non-mountainous land used for farming suffers from erosion. The embargo had severe economic impact on the life of the people as well as on project activities.

Many private organizations have helped to address the abundant needs of the island through the years: The Wesleyan Mission has the sole hospital on the island; Church World Services helps with creation and maintenance of roads through a "food for work" program; Episcopal and Catholic Churches manage a number of schools and dispensaries; since Jan 94 Medecins sans Frontieres has helped with the coordination between the organizations working on La Gonave, focusing on training and material/equipment donations.

World Vision (WV) became involved on La Gonave in 1976 with a child sponsorship program. In 1987 WV initiated a Child Survival project (CSP) on La Gonave, financed in part by USAID. Although the project was intended to serve the entire island, due to logistical difficulties, in 1989, the project was able to serve only seven of the eleven sections of the island. During the extension phase (1991-1994) , the project service area was once again expanded and the whole island was covered.

B. Project Staff and Activities

The project's main interventions included EPI, control of diarrhea1 diseases, nutrition promotion and growth monitoring, maternal care, family planning, and management of acute respiratory infections. These activities are carried out by a team consisting of a coordinator, an administrator, seven auxiliary nurses, 11 health and development committees, 100 health agents (agents de Sante, or ADS), 800 maternal health assistants (MHAs) and 350 traditional birth attendants (matrones).

In 7 of the 11 sections of La Gonave, WV has employed a nurse-auxiliary. The Government of Haiti's Ministry of Health (MOH) had

placed a government auxiliary in the four remaining sections but due to lack of funds these auxiliaries are not available any more. The nurse auxiliaries are responsible for training and supervising the community health committees and health agents in their section.

The health agents serve as resident home visitors, family trainers and health information reporters. They are responsible for immunizations, growth monitoring, and supervising the nutrition surveillance program, which also includes Vitamin A distribution. Each health agent was originally expected to cover about 30 households, but in fact each of them covers about 130 families.

Trained by the nurse auxiliaries, each health agent has identified, recruited and trained at least 20 volunteer maternal health assistants (MHAs). The role of the MHA is to motivate mothers to attend immunization and growth monitoring/counselling sessions; to encourage mothers to breastfeed; to promote the use of trained birth attendants (TBAs); and to reinforce teaching about oral rehydration therapy (ORT).

II. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Proiect Accomplishments

Al. The end of project objectives presented in the Detailed Implementation Plan (DIP):

1) Increase from 53% to 70% of children 12-23 months of age who have been fully immunized with EPI vaccines before their first birthday. End of Project (EOP) objectives for coverage with specific antigens were 95% for OPV, DPT and measles, and 80% for TT2 (among women age 15-45).

2) Ninety percent of mothers of children under two years of age correctly practice ORT when their child under two has diarrhea. Correct practice of ORT is defined as correct use of ORS, continued breast-feeding, and proper dietary management during and after episodes of diarrhea.

3) Seventy percent of mothers of children under five know the signs and symptoms of acute lower respiratory infection.

4) Health agents refer to the nearest health facility 65% of cases of ALRI among children under five.

5) Fifty percent of pregnant women with positive malaria smears will receive a full course of antimalarial therapy.

6) A decrease in prevalence of malnutrition among children under five from a 1990 baseline of 72% (Child Health Institute survey results) to 40%.

7) Increase the percentage of children 6 to 83 months of age receiving vitamin A capsules (VAC) from 49% to 70%.

8) Increase from 17% to 60% VAC coverage among new mothers (one dose within one month of delivery).

9) Increase from 33% to 40% contraceptive use among couples in union.

A2. Project accomplishments:

The table below presents:

1) the project objectives as outlined in the DIP and in the list of indicators commonly used for final evaluations of USAID-funded Child Survival projects.

2) the accomplishments of the project related to each objective, based on the results of the KPC survey conducted as one of the final evaluation activities of the WV CS project on La Gonave.

Table 1. Haiti CS Project Final Evaluation Survey: Indicators and Results

#	Indicators	Baseline Data	Object	Results
Nutrition				
1	Initiation of Breastfeeding- Percent of infants/children (less than 24 months old) who were breastfed within the first eight hours after birth.	47%	--	51.4%
2	Exclusive Breastfeeding- Percent of infants under four months of age who are being given only breast milk.	26%	--	73.0%
3	Introduction of Foods-Percent of infants between five and nine months of age who are being given solid or semi-solid foods.	91% (4-6 months)	--	17.5%
4	Persistence of Breastfeeding- Percent of children 20-24 months of age who are breastfeeding and being given solid/semi-solids.	86%	--	98.5%

Control of Diarrhea1 Disease				
5	Continued Breastfeeding—Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more breast milk.	44%	90%	89.6%
6	Continued Fluids-Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.	71%	80%	73.6%
7	Continued Foods-Percent of infants/children (less than24 months) with diarrhea in the past 2 weeks who were given the same amount or more food.	59%	80%	43.4%
8	ORT Usage—Percent of infants/ children (less than 24 months old) with diarrhea in the past two weeks who were treated with ORT.	--	80%	77.3%
9	Percent of mothers who know how to correctly mix ORS	--	90%	88.4%
Control of Pneumonia				
10	Recosnition- Percent of mothers with children under 60 months of age who know the signs and symtoms of acute respiratory infections, following WHO criteria.	50%	70%	56%'

'Calculated for mothers with children between 12-23 months of age.

11	Medical Treatment- Percent of mothers who sought medical treatment for infant/child (less than 24 months old) with cough and rapid, difficult breathing in the past two weeks.	--	70%	68.7%[2]
EPI (verified by cards)				
12	EPI Access-Percent of children 12-23 months old who received DPT1.	82%	95%	99.5%
13	EPI Coverage—Percent of children 12-23 months old who received OPV3.	70%	95%	94.6%
14	EPI Measles Coverace-Percent of children 12-23 months old who received measles vaccine.	57%	80%	76%
15	Drop-Out Rat-Percent change between DPTl and DPT3 doses [(DPT1-DPT3)/DPT1] for children 12-23 months old.	15%	-	5.4%
Maternal Care				
16	Maternal Card-Percent of mothers with a maternal card.	--	-	38.4%[3]
17	Tetanus Toxoid Coverase (Card)—Percent of mothers who received two doses of TT.	82%	80% (women 15-45)	90.1%
18	Percent of mothers knowing that TT protects both mother and infant.	--	85%	38.4%

[2]The results presented here understimate coverage for this indicator because the survey question referred to all children with cough, benign as well as severe, although it would be unlikely, and unnecessary, for mothers to seek medical advice for their child with a benign cough.

[3]The data collected in the 1991 baseline survey reported that 63% of mothers had maternal cards at that time.

19	Percent of mothers knowing that two doses of TT are required to protect against tetanus.	--	85%	89.5%
20	Antenatal Visits (Card)- Percent of mothers who had at least two antenatal visits prior to delivery.	--	-	78.7%
21	Modern Contraceptive Usage- Percent of mothers who desire no more children in the two next years, or are not sure, who are using a modern contraceptive method.	33%	40%	35.9%
Vitamin A Coverage				
22	Percent of children 12-23 months of age who will be beneficiaries of Vitamin A.	49%	70%	90.5%
23	Percent of pregnant women who will be beneficiaries of Vitamin A interventions by the third year of the project.	17%	60%	76.3%"

Comments: - has been used whenever there was no objective set for that specific indicator.

SURVEY RESULTS ANALYSIS

Discussion:

The 1991 baseline survey showed 53% coverage overall in the 11 sections of La Gonave served by this WV project. The end-of-project objectives included raising from 53% to 70% the proportion of children 12-23 months of age who are fully immunized (3 doses of DPT and OPV, one dose of BCG, and one dose of measles vaccine). The final evaluation survey conducted in the project area on La Gonave found that the project achieved significant improvements in coverage for each antigen, based on immunizations recorded on children's vaccination cards. The EOP objective was 95% coverage among children under two for each individual antigen; the final survey found that 90% or more of

[4] Calculated for just delivered women as the national policy in Haiti is to administer Vitamin A right after delivery not during pregnancy.

children under two had received DPT3 and OPV3 before their first birthday, and 76% of children were protected against measles. Although the project did not meet its objective of 95% coverage against measles, it did achieve an increase of nearly 20% of children under two who had received measles vaccine before their first birthday.

The number of mothers who gave their children with diarrhea the same amount or more breastmilk was 89.6%. While this is slightly short of the EOP goal of 95%, the project did achieve nearly a 100% increase over the baseline data of 44% of children with diarrhea receiving the same amount or more breastmilk.

Of ninety-six mothers whose child age 12-23 months had experienced cough and rapid, difficult breathing during the two weeks prior to the final survey, 66 mothers (69%) reported seeking medical treatment for their child. This compares favorably to the objective of 70% of mothers seeking medical treatment for their child with these symptoms of ALRI.

Explanation of the differences:

Many of the discrepancies between data reported at baseline and the data collected by the final survey are explained by differences in the questions themselves, as these questions used by WV during the baseline differed from the questions now provided by USAID in the guidelines for the CS project final reports. EPI and maternal care data collected by the 1994 final survey was confirmed with vaccination and maternal cards, which restricts the sample size. In particular, children's vaccination cards are perceived as being of greater value than mothers' cards, because children's cards are also used for identification, receipt of food rations, and admittance to certain religious services, while mothers cards do not entitle the holder to any special privileges.

The final survey results relating to nutrition are of some concern. While the DIP reported a baseline of 26% of children 0-3 months being exclusively breastfed, the Final survey was administered to mothers of children 12-23 months of age, thus the reported EOP level of 73.0% of infants 0-3 months of age exclusively breastfed is based on recall, rather than current practice. Although the data may be somewhat inflated, nevertheless it would appear that the project has achieved an increase in the proportion of infants 0-3 who are exclusively breastfed in the project area.

Data on the introduction of solid/semi-solid foods is difficult to compare, because the baseline figure of 91% refers to children 4-6 months of age, while the Final survey reports mothers' recall as to whether their children 12-23 months of age received solid/semi-solid foods while they were 5-9 months of age. Both problems with data based on recall, and food shortages during the recent embargo on Haiti likely contribute to the final survey's data reporting only 17.5% of children aged 5-9 months having received solid/semi-solid foods. Food shortages, and other problems associated with social unrest may also account for the decrease in the number of children 12-23 months who received the same amount or more food during an episode of diarrhea in the two weeks prior to administration of the survey.

Because of some limitations of some of the questions asked in the survey, certain indicators have been underestimated. For example: the final survey reports the percentage of mothers who sought medical treatment for child (12-23 months) with cough and rapid, difficult breathing in the past two weeks. Results for that indicator may be underestimated because the question does not differentiate between acute and benign coughing, and it would be unlikely, and unnecessary, for mothers to seek medical treatment for their child with a benign cough.

Unintended Benefits of Project Activities:

Besides the accomplishments of project activities, the WV CSP on La Gonave opened an opportunity to strengthen the relationship between other non-government organizations (NGOs) working on the island. It also contributed to consolidation of the World Vision ministry on La Gonave as it won the confidence of the population there. Subsequently, this reinforced the success of other WV projects such as child sponsorship, a water project, and land protection and food programs.

In addition, the success and the expertise gained as a result of the La Gonave CSP motivated development of similar projects in the northern and southern parts of the country by World Vision and facilitated the obtaining the necessary funds from the Association of Private Voluntary Health Organizations (AOPS).

Another unintended benefit was the initiation last year of a food aid program and a family planning program that have helped the population survive the hardships of the recent embargo.

B. Project Expenditures

Bl. See attached pipeline analysis of project expenditures.

B2,B3 Project expenditures and finance management.

In general expenses are carried out following World Vision financial guidelines. All expenses are justified and well documented. Financial requests have been filed and correctly signed.

Food purchased for the many workshops held on the La Gonave has been more expensive than food available in Port-au-Prince. This is explained by the fact that most of the food comes from Saint Marc, and transportation is costly.

B4 - Political instability in an underdeveloped country can make planning very difficult.

- The specialized guidelines of funding organizations makes it difficult for the community to manage all aspects of financial management of the project activities. Specialists in finance and bookeeping are necessary.

- Management training for community organizations is essential and must be continous.

c. Lessons Learned

C1) A continued supply of necessary material is essential.
It appears that the success of the WV Child Survival program is mainly due to very good planning which leads to a constant availability of material. Any stock failures have been few and short-lived.

C2) Zone regional committee are the basic for community participation
The WV CSP on La Gonave built a strong system of community participation with the involvement of the health committees, some of whose members are working as voluntary health agents in the program. (see Project sustainability).

C3) Discussing the project objectives, difficulties and successes with the local population increases their motivation.

C4) The health committee structure established in each section in the project area is sustainable within the section itself, but it is, perhaps, unrealistic to expect that the CSP could rely on these structures right away.

C5) It seems to be easier to involve women ***in*** the process of establishing health activities than to involve men.

C6) Most of the health committees are involved in income generating activities. Some of them are running activities which help the community to save money and improve their revenue. Sustainability can be achieved on a small scale. Income generating activities are appreciated by community committees, and are an incentive for project managerent.

C7) As expressed by the people interviewed, accessible services appropriate to the community's needs allow families to save energy, time and money. Community support is directly related to the perception that the activity is fullfilling needs identified by the community. If the activity addresses the needs expressed by the families it has a greater chance to succeed and be appreciated than one which has been imposed on the community by outsiders. That appreciation is a good motivator for the management of community activities.

C8) The supervision and financial reward of health agents should be the community's responsibility.

C9) Respect and trust for community health agents needs to developed, possibly through recognition events, badges, possibly uniforms, public congratulations, etc...

C10) The health committee should be encouraged to contact and interact with national agencies and institutions.

D. Recommendations

D1) Community system support

It is necessary that WV find means to reinforce these structures, to empower the health committees to sustain the CSP activities. This implies establishment of a community system promoting local training of trainers. Financial reinforcement of these committees should also to be considered for the monitoring of the CSP activities. Continued funding for these committees is a challenge that must be met if the CS activities are to continue. A suggestion would be to take into account project needs and expenses, such as transportation, when distributing income generating activity funds.

D2) Environmental issues

The latrinisation effort could be expanded; most of the people interviewed mentioned latrinisation activities. New roads would help in reaching the most remote population who still do not benefit from services because of the difficulties reaching them.

III. PROJECT SUSTAINABILITY

IIIA. Community Participation

A1) From September 20 to September 24, 1994, the evaluation team met with representatives from 6 of 11 committees. A list of representatives interviewed is provided in Table 2 (next page).

A2) According to community members and leaders, the following activities seem to be the most effective in meeting most urgent health needs of La Gonave's population:

- vaccination,
- education and/or formation of community's members such as committee's members, health agents, assistant mothers and matrons,
- family planning
- nutrition
- latrinisation
- potable water
- distribution of vit. A.

Latrinisation and potable water are provided through other projects run by WV on La Gonave in an integrated approach to development.

A3) As perceived by the community members and the leaders interviewed, through CSP, World Vision carried out activities which are meant to enable the communities to better meet their basic health needs and increase their ability to sustain effective child survival

interventions. Among these activities are the following:

l- establishment of health personnel in the section to provide basic curative services.

2- implementation of a health structure in each section to facilitate community development. The committees that form that structure are described in Table 2, below:

Table 2

Health Committee Representatives Interviewed

REPRESENTATIVE'S NAME	POSITION	SECTION REPRESENTED	SECTION #	IGA
Committee #1				
Robert Daphnus	Treasurer	Pointe a raquette	9 eme	yes
Edlan Georges	Treasurer Ass.			
Getel Petion	Secretary			
Allume Paulner	Member			
Lajeunesse Voisais	Secretary Ass.			
Rolle Lubin	Coordinator			
Committee #2				
Evelyne Cesar	Auxiliary	Grande Source	3 eme	yes
Wasner Souverain	Secretary			
Mme Laine Cantave	Treasurer			
Abner Sauveur	Vice President			
Committee #3				
Louis Lafable	Vice President	Palma	1 ere	yes
Mme Elcius Lauredent	Treasurer			
Robert Cemelus	Secretary			
Mme Violette Meradin	Auxiliary			
Committee #4				
Jean Jesuland	President	Grand Lagon	4 eme	no
Edmond Jean	Vice President			
Raymond Leblanc	Secretary			
Kester Jeanty	Member			
Antoine Celdeau	Animator			
Committee #5				
Joam Louis	President	Trou Louis	8 eme	no
Phito Deronville	Member			
Committee #6				
Thervo Maurilu	Treasurer	Petite Source	2 eme	no
Occeus Akish	Secretary			

3- Management of health material and drugs by the committees.

4- 1.E.C of populations for preventive medicine, hygiene and basic environmental health.

5-Motivation, sensitization and consciousness raising of populations in each section.

A4) Communities are key players in the whole process and activities of the CSP. They are important partners for managing the project and provide necessary human resources to realize such activities as construction of potable water and environmental protection systems.

They designate their health agents, responsible for implementing health programs in their localities.

They elect their health and development committees who decide, with the WV CSP, how to implement and evaluate their activities in such a way that they will achieve improvement. In external evaluations, the community provides information and recommendations on the whole project.

Every single activity to be implemented is discussed with the responsible committee. All income generating activities are proposed and initiated by the committees. They are anobligated to implement any given program within the section and serve as the nerve of the CSP activities.

A5) There are llhealth and development committees for the whole island, one in each section. Each section includes several zones subdivided into localities. For some sections, there are sub-committees which are located in the zones. The sub-committees are affiliated with the committees and they work along the same lines.

Each committee meets once or twice a month on a regular basis. Extraordinary sessions may be held. Normally committee members are elected by the Central Committee from people chosen by their community. Table 3 shows for each committee interviewed the number of sub-committees, the number of members, the frequency of meetings, and the schedule for the last meeting.

Table 3

Section No	Healthcommittee	No of members	No of monthly meeting	No of sub committees	last meeting
lere	Palma	15	2	11	09-21
3eme	Grande Source	9	2	9	09-19
4eme	Grand Lagon	9	2	0	09-01
5eme	Trou Louis	13	1	6	09-27
6eme	La Source	9	2	6	09-10
9eme	Pointe a Raquette	9	1	5	09-10

Health and development committees are elected for two years in a democratic process. One of the responsibilities of these committees is to discuss significant issues related to health and development activities in their sections. Table 4 (see ***next*** page) summarizes issues discussed in the last meeting for these six committees interviewed.

Another responsibility for the health and development committees is to assist the community. This assistance is provided by coordinating the following:

l- Eight (8) health auxiliaries are willing to serve the community. Each auxiliary is responsible for one or two sections. They are to provide curative services to the population. Most of them were born and are established on La Gonave and they participate in the health agents' formation process.

2- Health agents are a link between the community and the health and development committees. They ensure communities' education related to prevention and environmental health. They organize rally posts and make sure that vitamin A and vaccination are provided to children and breastfeeding mothers. Also, they help committees and sub-committees with food distribution and they participate in nutrition education for mothers. Roughly 100 health agents are currently working in the CSP with the committees.

3- It is also important to note that assistant mothers are playing a key role in the project. They are around 800 who had been trained on specific topic and are currently acting as trainers of trainees at community level.

A6-7 Many important issues hold the committees' attention.

Many of the leaders interviewed are concerned about the end of financial support from World Vision. Although they recognize they have been helped, organized and encouraged to take control of the project's accomplishments, they express their frustration for not having the financial means to meet the challenge.

Another issue is the food aid project, which many feel should be increased to cover all malnourished and needy children as well as school children and elderly.

In all, the committees are concerned about the raw poverty of the families and are pressing World Vision to find other funds to continue their aid to La Gonave.

A8) To ensure sustainability of the CS activities at the end of the project, communities invested at different levels:

a) Voluntary human resources -

Health and development committees worked on a voluntary basis to ensure the management of the project at their level. One hundred health agents have been working in the project on a voluntary basis and they are willing to continue to do so. Assistant mothers are participating actively to activities. They are trained to help the committees in the CSP activities. Matrons are also involved in the program as they share certain responsibility with the committees.

b) Other resources -

In most of the sections, community provided to the committees housing and lands to run income generating activities. Meetings are held at committee member's house in rotation.

Four (4) committees are running income generating activities to ensure sustainability at the end of the WV CSP project. Out of these 4 committees, 3 have been interviewed: Palma, Grande Source et Pointe a Raquette. It has been demonstrated from the interviews that committee members are well informed about the objectives and are managing mostly efficiently these activities.

A9) Among the factors which contributed to the success of income generating activities and motivated the committees to invest in these activities are:

- population's motivation, sensibilization and conscientisation.
- population's collaboration and involvement
- will of committee members
- cooperation with other members of the health structure such as auxiliaries, health agents, matrons, assistant mothers).
- populations' willingness to personally identify their needs as well as to participate in problem solving process.

Certain factors account for the limited results obtained. Among them it is important to note:

- poor financial management
- limited knowledge of management
- weaknesses in the health structure at macro level
- inaccessibility of certain communities due to bad or non-existent roads.

(see recommendations next page for table of issues),

ISSUES DISCUSSED

Health Committee	Date	Issue discussed	Decision adopted
Pointe a Raquette	09-10	. Inform the committee members about the project evaluation	. selection of the committee members to meet with the evaluation team
		. Vote of new regulations to improve management of the committee	Three absences at meeting will lead to member's dismissal.
Grande Source	39-19	. Inform the committee nembers about the project evaluation	Selection of the committee members to meet with the evaluation team.
		Inform and discuss a letter received from the CSP administration.	Preparation of the work plan for 94-95.
Palma	19-21	Notification of cases of severe malnutrition (M2,M3) in the section.	Ask for AK 1000 at the CSP central office.
		Local preparation of AK 1000.	Ask for grinders at CSP central office.
		Management of empty con tainers within the "food program".	Ask health agents to return empty containers to the committee.
Grand Lagon	39-01	Health agents activities.	Ask for improvement in efficiency of health agents and regularity in sub mission of report.
		Community education.	Promote participation of school teachers in health education within the section.
		Difficulties encountered in latrinisation project.	Ask for help and cooperation with other organizations working in the island.
Trou Louis	39-27	October monthly planning.	Ask health agents to respect the work plan.
La Source	09-10	Management of empty containers within the "food program"	Health agents and subcommittees must follow established norms for food distribution and recycling of empty containers.

IIIB. Ability and Willinsness of Counterpart Institutions to Sustain Activities.

B1) Representatives of all organizations working in La Gonave have been interviewed in other to answer to that point. They are all involved in preventive services and are main partners of World Vision on La Gonave. Table 5 presented below shows persons interviewed, their organization and their position.

Table 5

Person interviewed	Organization	Position
Dr. Eric Ferdinand	M.0.H *	Director of the programmatic area of La Gonave
Dr. Gabrielle Guersaint	Medecins sans Frontieres	Responsible for La Gonave Project
Rev. Fritz Valdema	Episcopal Church	Father responsible of La Gonave
Dr. Marie Line Hunter	Wesleyan Hospital	Medical Director
M. Jean Louis Pierre	World Vision	Administrator for La Gonav
Miss Emelyne Cesar	World Vision	Auxiliary-Section Grande Source
Dr. Florence Dyer	World Vision	Health Asssociate

* MOH = Ministry of Public Health and Population

B2) According to all the people interviewed, there are integrated activities between the CSP and the key health development agencies, with good collaboration. They complement and support each other. In this process collaboration is observed for education, provision of services and referral system for both curative and preventive services, community drugstore, common utilization and standardization of vaccination records to mention only these.

B3) Local institutions which are expected to take part in sustaining project activities are the Wesleyan mission Medecins sans Fontiere, Episcopal church.

B4) As far as these organizations interviewed are concerned, WV CSP is a necessity on La Gonave as it addresses real and urgent problems with the community. If WV CSP should withdraw, it will be a big hole. Currently none of the organizations working in La Gonave is able to sustain such activities. Even the MOH do not have financial resources to take over. MOH has been using WV and other agencies' facilities to ensure that MOH personel in La Gonave may work. According to all agencies interviewed, W'V CSP is doing a pretty good job and has become one of the most needed and succesfull program on La Gonave. Especially vaccination is perceived as being the most effective, followed by nutrition, although because of the embargo, certain problems have fuels shortage been experienced in the cold chain shortage of propane and in supervision of the health agents.

B5) Training has been a big component of the WV CSP strategy. They have been held jointly with Episcopal Church, Wesleyan Hospital, Medecins sans Frontieres and World Vision. They addressed all level of the health structure, especially health agents, auxiliary and nurses practicionners coming from and working with the previous organizations. Training also focussed on local people such as health and development committees members, assistant mothers.

B6) Although major project responsibilities and control have been shared with local organizations through health and development committees, mainly at implementation and local planification level, there is a lot to be done to ensure local management of CS activities.

Implementation aspect.- There is not to many problems on the field. Technically, health agents and committees members are capable to run CSP activities.

Planification and coordination aspect.- There is still a lot to be done. It could be necessary to create a central committee which will be focussing on receiving and mastering skills and competence to plan, coordinate and approach funding and collaborating agencies.

Intearation of the health and development committees.- Because of the strong philosophy of community participation promoted in all WV activities it will be important to strengthen integration of health committees to other local organizations (committees) working on other WV development projects.

Taking into account these considerations, it occurs that immediate withdrawal of WV is not suitable. Discharge still need to be phased. Regional committees are being implemented by WV to facilitate the integrating and coordinating process. This is an important step for effective global management of the program by the community.

B8-9 As far as the representatives of the organizations interviewed are concerned, there was no commitment to sustain CSP benefits and currently they are not able to make any. Mainly this is due to financial limitations of these organizations. WV would have to find by

itself means to continue the project activities for some more times.

B10) In country agencies which worked with World Vision on design implementation analysis of mid term evaluation and final evaluation on:

- MOH (ministry of health)
- IHE (Institute of Child Health)
- AOPS (Association of Private Health Agence)

IIIC. Attempts to Increase Efficiency

C1) To reduce costs WV strategy was to motivate and obtain community participation, to utilize local existing resources and collaborate with other local agencies to find health material and equipment.

To increase productivity, all personnel working in the project such as auxiliaries, health agents, assistant mothers etc. had been properly trained. More responsibilities had been given to community human resources in preventive services including community information and education. This increased disponibility of auxiliary for basic curative and more specialized services.

C2) That approach have been successful considering the implementation of a local structure which can assist communities to handle their health problems. Nonetheless, management skills, especially financial assistance need to be strengthened. It would be important to broading trained local human resources That would limit lost of resources and increase efficiency.

C3) Lessons learned:

1) It is essential to find a good approach to motivate and gain community participation.

2) Continuing training, information on all aspects of the project favor motivation, efficiency and transfer of knowledge to the communities.

3) Income generating activities strengthened community participation and unity of family as it created new interests and benefits to the families, improving their social and economical status.

IIID. Cost Recovery Attempts

D1) Through the CSP, WV allowed to health and development committees small loans and initial funds to run community drugstores and clinics, stockage business etc. Nevertheless, profits obtained are not sufficient to subvention CSP activities due to the level of poverty in the communities, (see next page, table 7 for more details). Funds generated from these activities are managed by local committees and are intended to serve financing CSP activities at WV CSP withdrawal.

D2) In an attempt to estimate the dollar amount of costs ***recovered*** during the project, we have to mention that out of 11 committees on La Gonave, eight are running income generating activities financed by WV CSP. Four of them have been interviewed in this final evaluation: Pointe a Raauette Grande Source, Palma which are runned by their health and development committee; Ti Palmiste runned by a Management committee.

Net Profit for all these committees has been 92,196.00 Haitian Gourdes, approximately US $30,732.00. There is a stock balance and a balance on loan evaluated at 30,262.40 Haitian Gourdes (US $10,087.46). Profit represents 56% of initial investment within one year.

Although these mechanisms and activities (drugstores, clinics, loans, stockage) do not generate enough to take in charge CSP activities, all committee members interviewed believed, even if for different reasons, that efforts invested are justified and worth it. 75% of those running drugstore activities and clinics think that it worths the efforts not only because of financial profit to the committee itself but again for sparing the community's time, energy and money. For them it makes a difference to have access to basic health care.

D3) 100% of committee members interviewed think that income generating activities have positively impacted WV reputation on La Gonave beyond the fact that they favor health services sustainability for the population. In fact health and development committees associate their success within any community activity to WV own success.

Services offered through clinics and community drugstores are almost free. They are intended to reach the poorer and more isolated communities and people. Taking into account financial status of these people, committee members noticed that even a very low interest rate on loan [illegible] affordable for most of them. Committees [illegible] are now willing to [illegible] ns to better serve their community at better costs.

D4) Although for different reasons health and development committee members agreed upon their relative success. Differences are mainly related to qualitative and quantitative standards. 75% see success because of intangible benefits such as access to services, 25% talked success because of tangible benefits such as profit margin.

D5) Any lessons learned:

1- Feasibility studies conducted in the communities prior to the implementation of any intome generating activity helps to avoid failure and important waste of resources.

2- Different issues relating to planning a community activity may be carefully studied and evaluated at regular intervals (every three months) with and by committee members to ensure success.

3- Small initial investment produces small return so it takes more time

to constitute a capital which would be able to sustain CSP activities and lead to auto-financemment.

4- Strong community organization favor success in community activity.

5- Selection criteria to elect committee members influence income generating activity success. Honesty, motivation and managerial skills are crucial.

6- The level of poverty of the community must be consided when starting an IGA.

7- In rural community, the families appreciate more an increase in "money circulation" than a steady increase of capital. The former has a bigger impact on their every day life and has an immediate relief effect.

IIIE. Household Income Generation

E1) Besides the fact that community is sparing money as the cost to face medical emergency has been drastically reduced, WV implemented through another organization means to increase directly household income generation. Through "Femmes en Action" (Women In Action) loans are directly allowed to families. Women can dispose of an appreciable amount of money to run income generating activities. Normally at the end of the year, they reconstitute the initial capital, some interest added -usually 3%-, constitute their own capital and are more aware to applicate management skills in their private life.

E2-3 Although it is difficult to evaluate the dollar amount of income added to family or household's annual income as a result income generating activity of the project it is to mention that for those families enrolled in these activities, because they can dispose of a cash, they have more opportunities for rational use and sparing of money. These loans had enable families to improve their daily household life as well as to buy animals and start a chicken, piglets) invest in farming, or improve their housing.

Another intangible benefit is the credibility added to health activities which leads people in the community to have a more rational approach to receive health message and deal with their health problems, decreasing expenses for health emergency.

All people interviewed think that in current situation, family revenues allow them to face health cost as contribution asked from committees at rally posts, drugstores and clinics are minimal. But if committees had to buy and charge the community for health material such as vaccines, seringes, intravenous fluids etc, health services may become non affordable for most of the population. That would have a negative impact on both family revenues and on possibility for family to meet

their health needs.

E4) Lessons learned from household income generation:

1- Existence of health services appropriated to the needs of the community allows family to spare energy, time and money, to invest in income generating activities.

2- Reception given to health services by communities is related to the community motivation in managing community activities.

3- Appreciation of the community is directly related to the fact that the activity is perceived as fulfilling needs identified by the community. If the activity addresses the needs expressed by the families it has more chances to succeed and be appreciated than one which have been imposed. That appreciation is a good motivator for the management of community activities.

4- Self-respect and self-fulfillment is an essential benefit of household income generating activities.

5- In rural communities women who benefits from small loan for household income generating activities, gain a solid credit in them the community. This allow them to improve their family's life.

IIIF. MIDTERM RECOMMENDATIONS

Although the final evaluation guidelines did not request a follow up on mid term evaluation recommendations, the team feels it is appropriate to state buefly the responses made to the last recommendation.

F1) Plainly, the health information system was targeted by the mid term evaluation.

Accordingly the CS staff has tried to follow the directive and suggestion of the team. A census was completed and rosters of under five and women 15 - 49 years exist in 60% of the localities. These rosters are used to help records data on children. However updating of these data, including newborn, new arrivals and departines has not been accomplished. The CS staff and health agents seen to think it is an impossible task, because of the difficult access of some localities and its time consuming aspect.

This is possibly the cause of undereporting services such as immunization since monthly report sheets show a coverage much lower than that estimated by the final survey.

F2) Immunization of children up to 0 - 15 years against measle was recommended by the mid term evaluation team. The project has started re-vaccination all children up 0 - 15 years against measles since November 93.

F3) Following the mid-term recommendation for nutrition, recuperation centers for severely malnourished children have been opened in Ti Palmiste. 33 of these children have been treated during the year and mildly malnourished children benefitted from dry rations.

IIIG. RECOMMENDATIONS

G1) The team recommendations that World Vision continues financial and technical assistance to the health committees of la Gonave until MOH can take over.

G2) The health committee of La Gonave should benefit from a continuing training program is community organization and project planification monitoring and evaluation.

G3) Financial capacity of local committees should be enhanced trough loans food for work. etc...

G4) Health + development committees of rural section should form a federation to interact with PVO's and MO for the development of La Gonave.

G5) The cold chain should be strengthened by adding 3 more refrigerators - solar powered would be best.

G6) MHA should be better recognized by their community. A badge or a uniform should be given to those that are productive. They should be utilized to upgrade the H.I.S.

G7) World Vision should increase its efforts in road and communication development with the assistance of local and uncountry organizations.

G8) Sanitation activities (potable water, latrinization) should be increased.

G9) Maternal care activities (information, prenatal and post natal care ect...) should be integrated in health services.

G10) The health committees should approach other local PVO to obtain some specific commitment for health and development of their community.

G11) Local qualified persons should be recruited and trained in specialized areas nursing, IEC, family planning) epidemiological surveillance nutrition, bookkeeping cold chain, sexually transmitted disesaser etc...

IV. EVALUATION TEAM

The team was composed of:

- Dr, Arsene Ferrus, M.D., MPH - Team coordinator
- Alexandre Canez, Sociologist - field survey coordinator
- Vasco Thernelan, Sociologist - focus group data collection and analysis
- Fred Leopold, Sociologist - focus group data collection and analysis
- Paul Brea - Data processing
- Maryse Gourdet, M.D., MPH - Reporter

This report has been written by Maryse Gourdet, M.D., MPH (consultant) based on data received from Arsene Ferrus team coordinator, Vasco Thernelan and Fred Leopold, assistants for focus groups realization, tabulation and analysis)

Schedule of activities:

1st day	Evaluation team meeting : orientation to project and preliminary work with evaluation team
2 - 4th day	Revision of protocol, methodology and questionnaires
5th day	Evaluation team meeting - final discussion
6th day	Finalization of forms and questionnaires
7th day	Departure to La Gonave - Training of interviewers started focus group with committees start.
8th day	Training of interviewers and questionnaire testing Focus group with committees - Interview of representatives of Wesleyan Hospital, Episcopal Church.
9 - 10th day	Data collection continued.
11th day	Data collection - Interviews with representatives of MSF and MOH - Departure from La Gonave.
12th day	Data entry
13th day	Data tabulation and analysis
14th day	Team meeting and discussion of results
15 - 18th day	Report writing - feed back to WV staff
19th day	Finalization of report.

WORLD VISION LA GONAVE CHILD SURVIVAL PROJECT
FINAL REPORT

APPENDIX 1

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

WVRDMEADQUARTERS
GRANT #PDC-0500-G-00-1065-00

COST ELEMENTS	Actual Expenditures to Date (10_/01_/91_ to _09/_30/_94)			Projected Expenditures Against Remaining Obligated Funds (_10/_01_/_94__ to _09_/_30/_95)			Total Agreement Budget (Columns 1 & 2) (_10/_01/_91 to _09/30/95_)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	$0	$0	$0	$2,925	$1,575	$4,500	$2,925	$1,575	$4,500
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants/Evaluation	0	0	0	4,875	2,625	7,500	4,875	2,625	7,500
SUB-TOTAL I	0	0	0	7,800	4,200	12,000	7,800	4,200	12,000
II. EVALUATION	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
SUB-TOTAL II	26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
III. INDIRECT COSTS	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
HQ/HO Overhead __20(%)									
SUB-TOTAL III	24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
IV. OTHER PROGRAM COSTS									
A. Personnel	97,188	13,523	110,711	29,899	54,909	84,808	127,087	68,432	195,519
B. Travel/Per Diem									
1. In-country	2,365	676	3,041	35,514	19,720	55,234	37,879	20,396	58,275
2. International	24,309	5,510	29,819	(12,609)	790	(11,819)	11,700	6,300	18,000
C. Other Direct Costs	927	310	1,237	4,923	2,840	7,763	5,850	3,150	9,000
'(Utilities, Printing, Rent, maintenance, etc.)									
SUB-TOTAL IV	124,789	20,019	144,808	57,727	78,259	135,986	182,516	98,278	280,794
TOTAL	$149,777	$24,022	$173,801	$101,085	$111,057	$212,142	$250,862	$135,079	$385,941

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORMA

PVO/COUNTRY PROJECT: WORLD VISION RELIEF AND DEVELOPMENT/
HAITI CHILD SURVIVAL PROJECT
GRANT NO. PDC-0500-G-00-1065-00

COST ELEMENTS	Actud Expenditures to Date (09/30/91 to 09130194)			Projected Expenditures Against Remaining Obligated Funds --End of Grant--			Total D.I.F. Budget (Columns 1 & 2) (09/3-0/91 to 09/30/94)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
1. PROCUREMENT									
A. Supplies	$3,105	56,401	$9,506	$13,395	($3,401)	$9,994	$16,500	$3,000	$19,500
B. Equipment	0	52,237	52,237	0	1,263	1,263	0	53,500	53,500
C. Services/Consultants	6.109	Q	6.109	5.391	3.600	8,991	11.500	3.600	15.100
SUB-TOTAL i	9,214	58,638	67,852	18,786	1,462	20,248	28,000	60,100	88,100
II. EVALUATION	0	0	0	15,256	0	15,256	15,256	0	15,256
SUB-TOTAL II	0	0	0	75,256	0	15,256	15,256	0	15,256
III. INDIRECT COSTS	63,289	149,537	212,826	0	11,255	11,255.	63,289	160,792	224,081
HQ/HO Overhead __20(%)									
SUB-TOTAL 111	63,289	149,537	212,826	0	II.255	1 1,255	63,289	160,792	224,081
IV. OTHER PROGRAM COSTS									
A. Personnel	208,016	15,301	223,317	24,525	(6,512;	18,013	232,541	8,789	241,330
B. Travel/Per Diem	25,534	9,365	34,899	(16,494:	(4,245;	(20,739)	9,040	5,120	14,160
C. Other Direct Costs	73.669	9.616	83.285	(42 073;	1.694	(40,379)	31.596	11.310	42.906
'(Utilities, Printing, Rent, maintenance, etc.)									
SUB-TOTAL IV	307,219	34,282	341,501	(34,042:	(9,063)	(43,105:	273,177	25,219	298,396
TOTAL	$379,722	$242,457	$622,179	$0	$3,654	$3,654	$379,722	$246,111	$625,833

WORLD VISION LA GONAVE CHILD SURVIVAL PROJECT
FINAL REPORT

APPENDIX 2

PVO World Vision COUNTRY Haiti **FUNDING** YEAR FY91

New or Expansion Project Expansion **Baseline or Final Survey** Final

#	INDICATOR (submit results only for indicators that reflect project interventions)	**RESULTS** Numerator (N) Denominator (D) Percent (P)
1	NUT: Initiation of Breastfeeding - Percent of infants/children (less than 24 months) who were breast-fed within the first eight hours after birth.	N= 107 P= 51.4% D= 208
2	NUT: Exclusive Breastfeeding - Percent of infants under four months, who are being given only breast milk.	N= 152 P= 73 D= 208
3	NUT: Introduction of Foods - Percent of infants between five and nine months, who are being given solid or semi-solid foods.	N= 37 P= 17.5 D= 211
4	NUT: Persistence of Breastfeeding - Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).	N= 64 P= 98.5 D= 65
5	CDD: Continued Breastfeeding - Percent of infants/children with diarrhea in the past two weeks who were given the same amount or more breast-milk.	N= 26 P= 89.6 D= 29
6	CDD: Continued Fluids - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.	N= 39 P= 73.6 D= 53
7	CDD: Continued Foods - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.	N= 23 P= 43.4 D= 53
8	CDD: ORT Usage - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.	N= 41 P= 77.3 D= 53
9	Pneumonia Control: Medical Treatment - Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.	N= 66 P= 68.7 D= 96
10	EPI: Access - Percent of children 12 to 23 months who received DPT1.	N= 203 P= 99.5 D= 204
11	EPI: Coverage - Percent of children 12 to 23 months who received OPV3.	N= 193 P=94.6 D= 204
12	EPI: Measles Coverage - Percent ofchildren 12 to 23 months who received Measles vaccine.	N= 155 P= 76 D= 204
13	EPE Drop Out Rate - Percent change between DPT1 and DPT3 doses [(DPT1-DPT3) ÷ DPT1] for children 12 to 23 months.	N= 11 P=5.4 D= 203
14	MC: Maternal Card - Percent of mothers with a maternal card.	N= 81 p-38.4 D= 211
15	MC: Tetanus Toxoid Coverage (Card) - Percent of mothers wbo received two doses of tetanus toxoid vaccine (card).	N= 73 P=90.1 D= 81
16	MC: Ante-Natal Visits (Card) - Percent of mothers who had at least one ante-natal visit prior to the birth of the child (card).	N= 166 P=78.7 D= 211
17	MC: Modern Contraceptive Usage - percent of mothers who desire no more children in the next two years, or are not sure, who are using a modem contraceptive method.	N= 64 P=35.9 D= 178

COMMENTS:

WORLD VISION LA GONAVE CHILD SURVIVAL PROJECT
FINAL REPORT

APPENDIX 3

WV/Haiti La Gonave Child Survival Project
Final Evaluation KPC Survey
Methodology

A. The Questionnaire

A questionnaire was administered within the La Gonave project site to mothers aged 15-45 years with a child from 12 to 23 months of age.

The questionnaire was designed to reflect the objectives of the WV La Gonave project and the indicators recommended for final evaluation of all USAID-funded Child Survival projects.

The questionnaire (attached) was written in Haitian Creole, the popular language of the Republic of Haiti, and was pretested and on La Gonave and modified as required prior to the formal survey.

The questionnaire used contains six sections:

- Parts I and II focus on breastfeeding, nutrition, weaning practices, mothers understanding of vitamin A and recognition of foods with high vitamin A content, vitamin A distribution, and children's growth monitoring records/histories.
- Part II covers mothers' knowledge and practices regarding management of diarrheal disease in their child.
- Part IV deals with acute respiratory infections (ARI).
- Parts V and VI focus on immunization of children and mothers, availability of immunization cards, knowledge of tetanus toxoid, pregnancy and prenatal care, post-natal distribution of vitamin A, and family planning practices.

B. Sample Selection

For the final evaluation, it was decided to conduct the survey in the same clusters used for the Mid-term evaluation, since that would reinforce comparability between the mid-term results and the final evaluation. Within these 30 clusters, the survey was conducted according to standard cluster sampling techniques recommended by WHO.

Seven mothers aged 15-45 years with a child age 12-23 months were interviewed in each cluster. The village church, or else the village open market in each village served as the selection starting point within each cluster, as these are usually located in the center of the village. The first household encountered when walking to the right of the referral point church or market was the starting point. Interviewers then continued walking to the right, visiting each house until seven women with at least one child aged 12-23 months had been interviewed in the cluster.

This method was followed in each cluster, until a total of 211 mothers had been interviewed and data collected for 210 children of the correct age.

C. The Survey

Training. The survey team was composed of a team evaluator (three health professionals and three WV field staff) and 30 interviewers chosen from among the Community Health Workers (CHWs).

The 30 interviewers received two days of training covering the purpose of the survey and the meaning and significance of each section of the questionnaire. The interviewers also participated in the pilot testing of the survey questionnaire, and in the post-test session discussing the adjustments to be made in the questionnaire.

Interviews. The CHWs conducted their interviews during a two day period. Since the interviewers were project employees, every effort was made to ensure the validity of the data collection process and minimize possible bias. None of the CHWs conducted interviews in the zones/communities where they work. The quality of the data collected was verified by senior members of the evaluation team, each of whom supervised 15 interviewers.

Method of Data Analysis. Data was entered and analyzed on SPSS, and frequencies, distributions and cross tabulations were generated.

D. Survey Results

The survey results are presented in the following table, which compares the current levels of the WV Child Survival project indicators with baseline data collected prior to initiation of this project and the objectives presented in the project Detailed Implementation Plan.

Haiti CS Project Final Evaluation Survey: Indicators and Results

#	Indicators	Baseline Data	Object	Results
Nutrition				
1	Initiation of Breastfeeding- Percent of infants/children (less than 24 months old) who were breastfed within the first eight hours after birth.	47%	--	51.4%
2	Exclusive Breastfeeding- Percent of infants under four months of age who are being given only breast milk.	26%	--	73.0%
3	Introduction of Foods-Percent of infants between five and nine months of age who are being given solid or semi-solid foods.	91% (4-6 months)	--	17.5%
4	Persistence of Breastfeeding- Percent of children 20-24 months of age who are breastfeeding and being given solid/semi-solids.	86%	--	98.5%
Control of Diarrheal Disease				
5	Continued Breastfeeding— Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more breast milk.	44%	90%	89.6%
6	Continued Fluids-Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.	71%	80%	73.6%
7	Continued Foods--Percent of infants/children (less than24 months) with diarrhea in the past 2 weeks who were given the same amount or more food.	59%	80%	43.4%

8	ORT Usage—Percent of infants/ children (less than 24 months old) with diarrhea in the past two weeks who were treated with ORT.	--	80%	77.3%
9	Percent of mothers who know how to correctly mix ORS	--	90%	88.4%
Control of Pneumonia				
10	Recosnition- Percent of mothers with children under 60 months of age who know the signs and symtoms of acute respiratory infections, following WHO criteria.	50%	70%	56%'
11	Medical Treatment- Percent of mothers who sought medical treatment for infant/child (less than 24 months old) with cough and rapid, difficult breathing in the past two weeks.	--	70%	68.7%[2]
EPI (verified by cards)				
12	EPI Access-Percent of children 12-23 months old who received DPT1.	82%	95%	99.5%
13	EPI Coverage-Percent of children 12-23 months old who received OPV3.	70%	95%	94.6%
14	EPI Measles Coverage-Percent of children 12-23 months old who received measles vaccine.	57%	80%	76%
15	Drop-Out Rate—Percent change between DPTl and DPT3 doses [(DPT1-DPT3)/DPT1] for children 12-23 months old.	15%	-	5.4%

'Calculated for mothers with children between 12-23 months of age.

[2]The results presented here understimate coverage for this indicator because the survey question referred to all children with cough, benign as well as severe, although it would be unlikely, and unnecessary, for mothers to seek medical advice for their child with a benign cough.

Yaternal Care				
16	Maternal Card-Percent of mothers with a maternal card.	--	-	38.4%[3]
17	Tetanus Toxoid Coverage (Card)-Percent of mothers who received two doses of TT.	82%	80% (women 15-45)	90.1%
18	Percent of mothers knowing that TT protects both mother and infant.	--	85%	38.4%
19	Percent of mothers knowing that two doses of TT are required to protect against tetanus.	--	85%	89.5%
20	Antenatal Visits (Card)-Percent of mothers who had at least two antenatal visits prior to delivery.	--	-	78.7%
21	Modern Contraceptive Usage-Percent of mothers who desire no more children in the two next years, or are not sure, who are using a modern contraceptive method.	33%	40%	35.9%
Vitamin A Coverage				
22	Percent of children 12-23 months of age who will be beneficiaries of Vitamin A.	49%	70%	90.5%
23	Percent of pregnant women who will be beneficiaries of Vitamin A interventions by the third year of the project.	17%	60%	76.3%[4]

Comments: - has been used whenever there was no objective set for that specific indicator.

---

[3]The data collected in the 1991 baseline survey reported that 63% of mothers had maternal cards at that time.

[4]Calculated for just delivered women as the national policy in Haiti is to administer Vitamin A right after delivery not during pregnancy.

Number of People Interviewed per Cluster

#	CLUSTERS	FREQUENCY	#	CLUSTERS	FREQ.
01	La Palmiste	7	02	Nan Plume	8
03	Ti Coma	7	04	Grande Plaine	7
05	Nan Sema	7	06	Mare Sucrin	7
07	Cherissable	7	08	Sous Saline	7
09	Debaleine Sud	7	10	Nan Coton	8
11	Grande Source	6	12	Grand Vide	7
13	Grande Soufriere	7	14	Grand Marigot	7
15	Trou Louis	7	16	Fond Negres	8
17	Trou Chouc	5	18	Debaleine Nord	7
19	Dorval	8	20	Te Seche	7
21	Gros Mapou	7	22	Grand Lagon	7
23	Baie Tortue	7	24	Nan Sylvestre	7
25	Fond Plaisir	7	26	Zeb Guinin	7
27	Pique Meby	7	28	Gros mangle	7
29	Morne Trou Jack	7	30	Nan Lacou	7
		103			108
	TOTAL 211 Clusters				

LIST OF INTERVIEWERS

SUPERVISOR	#	TEAM OF INTERVIEWERS
A. Ferrus	01	Jonel Poulard - Thera Exanord
	02	Julme Lexima - Lunice Fanfan
	03	Delcarme Borgela - Mme Camil Angrand
	04	Micilien Denose - Cemelus Tesner
	05	Monvil Camil - Faskel Merilus
	06	Georges Edlant - Jn Elouhode Mersier
	07	Getel Petion - Mme Brunel Sagaille
Cane2	08	Lyse Honore - Ginette Joseph
	09	Mme Luciana Larose - Mme Sagaille Monique
	10	Paulner Allume - Raymonde St Fleur
	11	Damice Charles - Moise Brice
	12	Geneus Valliere - Paul Bolivar
	13	Lubin Rolle - Lubin Wilson
	14	Philistin Michel - Lajeunesse Voisais
	15	John Wesley F. Candy Paul - Etzer Bebe

WORLD VISION LA GONAVE CHILD SURVIVAL PROJECT
FINAL REPORT

APPENDIX 4

KESYONE SOU KONESANS AX ATITID MANMAN/GADO TIMOUN

SE POU OU POZE TOUT KESYON AK TOUT MANMAN (FANM KI GENYEN LAJ SOT1 NAN 15 RIVE NAN 49 LANE) KI GENYEN YON TIMOUN KI POKO RIVE GENYEN DE (2) LANE (TIMOUN KI GENYEN PI PIT1 PASE 24 MWA).

DAT PREMYE VIZIT LA 1 -|J- | |-|M- - | |__|__|A

DAT DEZYEM VIZIT LA | - J - | |__|__|M |__|__|A

IDANTIFIKASYON KESYONE AN L -|G- | |-L- | |__|__|M

NIMEWO EKIP LA |-|-|

NON AK NIMEWO ANKETE AN _____ |__|__|

Non manman/Gadb timoun nan _____

Laj manman/Gadb timoun nan 1 -|-| Ane

Nan ki mwa ak nan ki lane ou te fèt |__|__|M |__|__|A

Non ak laj timoun ki poko rive genyen de (2) lane (Timoun ki pi piti an)

_____ Laj |__|__| Mwa

Ki dat timoun sa te fèt |__|__|J |__|__|M |__|__|A

SEKSYON 1- TIMOUN NAN TETE / NITRISYON

No	KESYON	REPONS	RANVWA
1	Eske timoun sa nan tete toujou?	Wi _____ 1 Non --- _____ 2	----->3
2	Eske timoun sa ou te konn bali tete?	Wi _____ 1 N o n _____ 2	---->7

No	KESYON	REPONS	RANVWA
3	Sou konbyen tan apre ou te fin akouche ou te bay ti moun nan tete pou premye fwa	Menm jou an_____ 1 Aprè yon jou____ 2 Aprè 2 jou_____ 3 Aprè + ke 2 iou- 4	
4	Eske ou te konn bay ti moun sa tete selman jiska's ke li genyen 3 mwa?	Wi _____ 1 Non_____ 2	
5	Sou konbyen mwa ou te kòmanse bay ti moun sa manje lot kalite manje?	Avan 5 mwa_____1 an 5 rive _____2 Aprè 9 mwa_____3	
6	Eske ou te pije lèt nan tete ou jete, anvan ou te komanse bay timoun sa tete pou premye fwa?	Wi _____ 1 Non_____ 2	
7	Kisa yon manman ki fek akouche kapab fè pou lèt li kapab koule? (PLIZYE REPONS POSIB)	Komanse bay timoun nan tete 1 Evite bay timoun nan bwè nan bibon-2 Bay timoun nan tete souvan_____ 3 Byen swen pwent t e t e _y o_____ 4 Lot _____ 5 (precisez) Pa konnen_____99	
8	Eske ou kohn bay timoun sa bwè nan bibon?	Wi _____ 1 Non _____ 2	

No	KESYON	REPONS	RANVWA
9	Aprè konbyen tan yon manman ta dwe komanse bay yon timoun manje lot bagay aprè lèt manman li?	Aprè 1 mwa _____ 1 Aprè 2 mwa _____ 2 Aprè 3 mwa _____ 3 Aprè 4 mwa _____ 4 Aprè + ke 4 mwa_ 5 Pa Konnen _____ 99	
10	Eske ou konn bay timoun sa manje bagay sa yo tankou: Kawbt, Joumou, Papay, mango?	Wi _____ 1 Non _____ 2	
11	Eske ou konn bay timoun sa manje legim fey sa yo tankou: Zepina, Lyann panye?	Wi _____ 1 Non _____ 2	
12	Ki kalite manje ki bon pou pwoteje je timoun? Pluzye respons posib	legim fey vèt _____ 1 Fwi ki gen koulè jbnn _____ 2 Vyann/Pwason _____ 3 Lèt Manman _____ 4 Jdnn ze _____ 5 Lèt _____ 6 Pa konnen _____ 99 Lot _____ 8 (precisez)	
13	Eske ou konn mete bagay sa. yo nan manje timoun sa tankou: Grès, Lwil?	Wi _____ 1 Non _____ 2	

SEKSYON 2- SIVEYANS KWASANS TIMOUN			
No	KESYON	REPONS	RANVWA
1	Eske timoun sa genyen yon kat Chemen Sante? MANDE WE KAT LA	Wi _____ 1 Non _____ 2	 -->5
2	Eske timoun sa te peze nan twa (3) dènye mwa ki soti pase yo?	Wi _____ 1 Non _____ 2	
3	Eske timoun sa te pran Vitamin A?	Wi _____ 1 Non _____ 2	 ---->5
4	EKRI DAT TIMOUN SA TE PRAN VITAMIN A YO KI SOU KAT LA.	J M A 1) |- |- || - | - || -| -| 211- | -||__|__||__|__|	
5	Poukisa yon timoun dwe pran Vitamin A?	_____ _____ _____ Pa Konnen _____ 99	

SEKSYON 3- MALADI DYARE			
No	KESYON	REPONS	RANVWA
1	Eske timoun sa te genyen dyare nan de (2) semen ki soti pase yo rive jodi an?	Wi _____ 1 Non _____ 2	---->13
2	Eske ou te bay timoun sa tete pandan li te genyen dyare an?	Wi _____ 1 Non _____ 2 Sevre _____ 3	----->4 ----->6
3	Poukisa ou pat bali tete pandan li te genyen dyare an?	_____ _____ _____	PASE NAN NIMEWO 5
4	Eske timoun sa te tete lè li te genyen dyare an:	Plis ke avan lè li te gen dyare an _____ 1 Mwens ke avan lè li te gen dyare an _____ 2 Kom avan lè li te gen dyare an _____ 3	
5	Eske ou te bali bwb plis lot bagay aprb tete an pandan li te genyen dyare an?	Wi _____ 1 Non _____ 2	----->7
6	Eske timoun sa ou te bali bwè lòt bagay lè li'te genyen dyare an?	Plis-ke avan lb li te gen dyare an _____ 1 Mwens ke avan lè li te gen dyare an _____ 2 Kòm avan lè li te gen dyare an _____ 3	

No	KESYON	REPONS	RANVWA
7	Eske timoun sa te manje **pandan** li te genyen dyare an?	Wi _____ 1 Non _____ 2	--->g
8	Eske ou te bay timoun sa manje **lè** li te genyen dyare an:	Plis ke **avan lè** li te gen dyare an _____ 1 Mwens ke **avan lè** li te gen dyare an _____ 2 Kbm **avan lè** li te gen dyare an _____ 3	
9	**Lè** timoun sa te genyen dyare an kisa ou te **fè** pou sa? (PLIZYE REPONS POSIB)	Anyen _____ 1 Sewom Oral **Sachè** _____ 2 Sewom Lakay _____ 3 Diri ak Kawot, Dlo Diri, Labouyi Lamidon _____ 4 Rafrechi, Te _____ 5 Medikaman pou dyare 6 Lot _____ 7 (precisez)	
10	LB timoun sa te genyen dyare an eske ou te **chèche** konsey oubyen **tretman nan men lot moun?**	Wi _____ 1 Non _____ 2	--->12

No	KESYON	REPONS	RANVWA
11	Ki moun ki te ba ou konsey lè sa sou zafè dyare an? (PLIZYE REPONS POSIB)	Lopital Wesleyen _____ 1 Sant/Dispansè _____ 2 Pos rasanbleman _____ 3 Miss _____ 4 Ajan Sante _____ 5 Doktè-Fey _____ 6 Ougan _____ 7 Fanm Saj _____ 8 Paran/Fanmi _____ 9 Lot _____ 10 (precisez)	
12	Daprè ou kisa ki pi enpotan pou fè pou timoun ki genyen dyare? (PLIZYE REPONS POSIB)	Mennen timoun nan lopital/Sant Sante 1 Bay timoun nan bwè plis ke-abitid 2 Bay timoun nan manje repa ki pi piti men plizye fwa pa jou _____ 3 Pa bay timoun nan bwè anyen _____ 4 Pa bay timoun nan manje anyen _____ 5 Bay timoun nan sewom oral _____ 6 Bay timoun nan tete 7 Pa konnen _____ 99 Lot _____ 9 (precisez)	

No	KESYON	REPONS	RANVWA
13	Lè yon timoun soti anb yon maladi dyare kisa ki pi enpotan pou ou fè pou li? (PLIZYE REPONS POSIB)	Bay timoun nan manje repa ki pi piti men plizye fwa pa jou. 1 Bay timoun nan manje plis ke dabitid____ 2 Bay timoun nan manje ki chaje ak enèji_____ 3 Pa konnen_____ 99 Lot_____ 5 (precisez)	
14	Eske ou konn tande pal de Sewom Oral?	Wi _____ 1 Non_____ 2	---->16
15	Kijan ou konn prepare Sewom Oral nan sachè?	_____ _____ _____ Pa Konnen_____9 9	
16	Eske ou konn tande pal de Sewom Lakay?	Wi _____ 1 Non_____ 2	----->18
17	Kijan ou konn prepare Sewom Lakay?	_____ _____ _____ Pa Konnen_____ 99	
18	Lè timoun yo konn genyen dyare an eske ou tekonn bayo bwb Sewom Oral?	Wi _____ 1 Non_____ 2	

SEKSYON 4- MALADI BWONCH			
No	KESYON	REPONS	RANVWA
1	Eske timoun sa te genyen grip oubyen tous nan de (2) semen ki soti pase yo rive jodi an?	Wi _____ 1 Non _____ 2	---->5
2	Eske timoun sa tap soufle anlè lè li te genyen grip sa?	Wi _____ 1 Non _____ 2	
3	Eske ou te ale chache konsey oubyen tretman pou timoun sa lb li te genyen grip la oubyen tous la?	Wi _____ 1 Non _____ 2	--->5
4	Ki kote ou te ale chèche konsey oubyen tretman pou sa? (PLIZYE REPONS POSIB)	Lopital Wesleyen _____ 1 Sant/Dispansè _____ 2 Pos rasanbleman _____ 3 M i s s _____ 4 Ajan Sante _____ 5 Doktè-Fey _____ 6 Ougan _____ 7 Fanm Saj _____ 8 Paran/Fanmi _____ 9 Lot _____ 10 (precisez)	

No	KESYON	REPONS	RANVWA
5	Daprè ou ki siy ou kapab wè si yon timoun genyen maladi yo rele Bwonch la IRA?	Li pran souf rapid ou ak figilte_____ 1 Tout zo kbt timoun nan paret lè li rale souf li_____ 2 Pèdi apeti/ pa vle manje_____ 3 Tous/Gripe/Arimen___ 4 Pa konnen_____ 99 Lot_____ 6 (precisez)	
6	Kilè ou ka di yon timoun grav lè li genyen maladi bwonch IRA?	Li pran souf rapid ou ak figilte_____ 1 Tout zo kbt timoun nan paret lè li rale souf li_____ 2 Pèdi apeti/ pa vle manje_____ - 3 Tous/Gripe/Arimen 4" Pa konnen_____ 99 Lot_____ 6 (precisez)	

SEKSYON 5- VAKSEN IMINIZASYON TIMOUN			
No	KESYON	REPONS	RANVWA
1	Eske timoun sa konn pran vaksen deja Mande wè kat la	Wi _____ 1 Non _____ 2	
2	Eske ou genyen yon kat vaksen pou timoun sa?	Wi _____ 1 Non _____ 2	-->ALE NAN SEKSYON 6
3	RANPLI TABLO SA AVEK ENFOMASYON OU JWENN SOU KAT VAKSEN AN. VAKSEN BCG DTP 1 DTP 2 DTP 3 POLIO 0 POLIO 1 POLIO 2 POLIO 3 WOUJOL	DAT VAKSEN YO J M A |__|__| |__|__| |__|__| |__|__| |__|__| | - | - | . |__|__| |__|__| |__|__| |__|__| |__|__| | - 1 - | |__|__| 1 - |- | |- |- | |__|__| |__|__| j - | - 1 |__|__| |__|__| |__|__| |__|__| |- |- | - | - |_ | |__|__| |__|__| |__|__|		

SEKSYON 6- SWEN MATENEL/ VAKSEN TETANOS TOKSOYID			
No	**KESYON**	REPONS	**RANVWA**
1	Eske ou menm ou genyen yon kat vaksen? Mande **wè** kat la	Wi _____ 1 Non_____ 2	 ----->3
2	RANPLI TABLO SA A AVEK ENFOMASYON KI SOU KAT VAKSEN AN. VAKSEN TETANOS T. 1 TETANOS T. 2	DAT VAKSEN YO J M A |__|__| |__|__| |__|__| |__|__| |__|__| |- 1 - |	
3	***Ki*** kalite vaksen yon fanm dwe pran **lè** li ansent?	Tetanos .t_____ 1 Polio _____ 2 DTP _____ 3 ' L o t _____ ' 4 (precisez)PK -99	
4	**Poukisa** yon fanm **ansent** bezwen pran vaksen tetanos?	_____ _____ _____ Pa Konnen - 99 -	
5	Konbyen **doz vaksen** tetanos **yon fanm ansent** dwe pran pou li ka-pwoteje **bebe li pral fè an kont** tetanos?	|_|__| doz **Pa** konnen_____ 99	
6	**Eske ou ansent kounye** an?	**Wi** _____ 1 **Non**_____ 2	

No	KESYON	REPONS	RANVWA
7	Sou Konbyen mwa yon fanm **ansent** ta dwe ale nan Sant Sante/Lopital pou la premye fwa?	|__|__| mwa Pa Konnen_____ 99	
8	Eske ou te ale konsilte nan yon Sant Sante **lè** ou te ansen timoun sa?	Wi _____ 1 Non_____ 2	---->lO
9	Konbyen fwa ou te ale nan Sant Sante an **pandan** ou te **ansent** la?	|__|__| **fwa** Pa Sonje_____ 88	
10	Eske ou te jwenn Vitamen A **lè** ou te **fini** akouche timoun sa?	Wi _____ 1 Non_____ 2	
11	**Daprè** ou poukisa yon fanm ki **fini** akouche ta dwe pran Vitamin A?	_____ _____ _____ Pa Konnen_____	99
12	Eske ou ta renmen **fè** yon ti [illegible] timoun nan de (2) lane kap vini yo?	Wi _____ 1 Non _____ 2	----Fen
13	Eske ou menm oswa **mari** ou ap swiv yon metod **Planin** kounye an?	Wi _____ 1 Non_____ 2	----Fen

No	KESYON	REPONS	RANVWA
14	Avek ki metod **Planin** wap **sèvi** kounye an?	Ligati _____ 1 **Noplan** _____ 2 Piki _____ 3 Grenn, Pilil _____ 4 Filaman **(esterilè)** 5 Dyafragm _____ 6 Kapot _____ 7 Jel, Krem _____ 8 Bay **tete** _____ 9 Metod Almanak _____ 10 Pa **fè** bagay menm ___ 11 **Retrè** (Voye deyo) 12 Vazektomi _____ -13. L o t _____ 14 (precisez)	

REMAK: _____